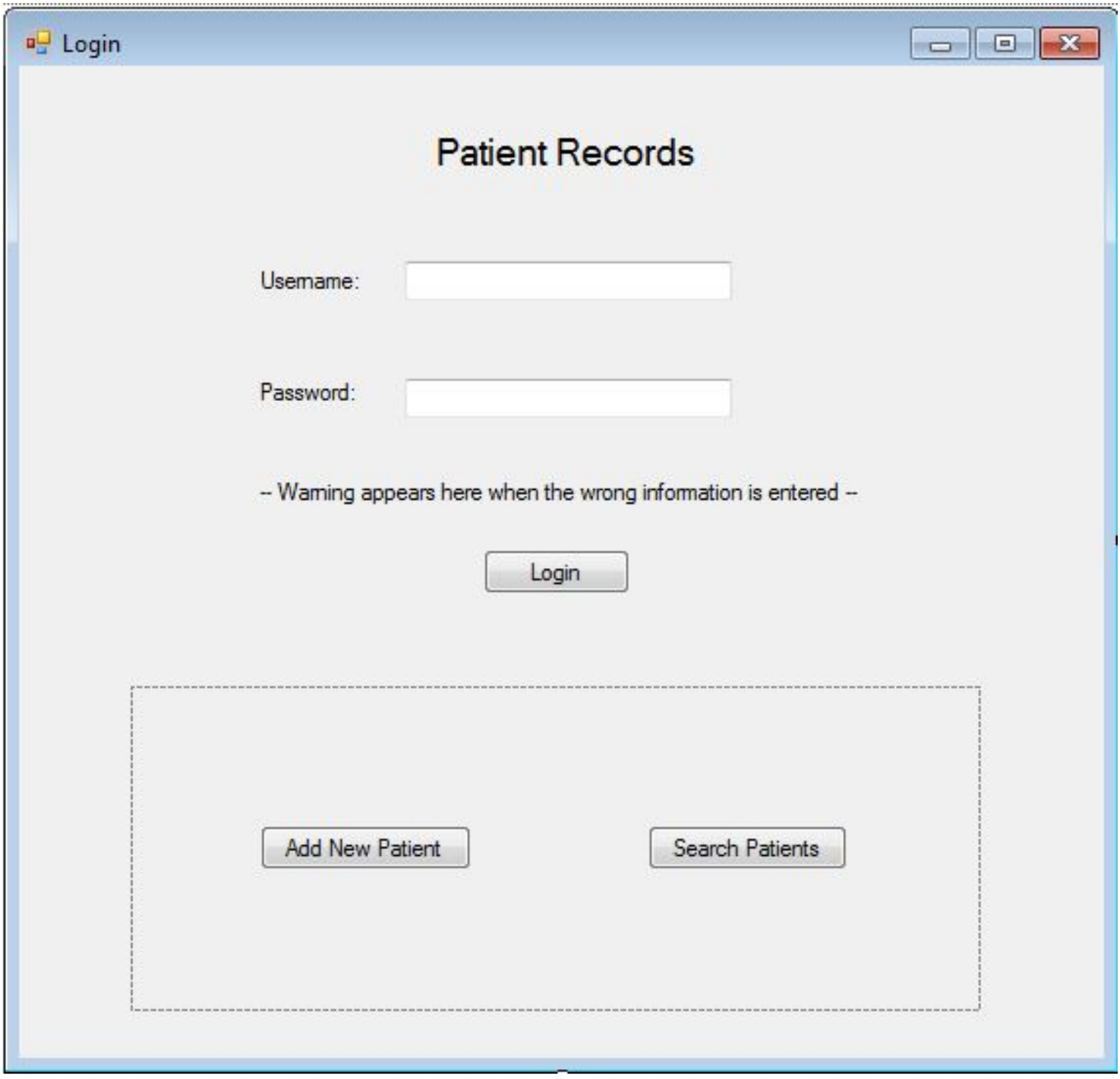
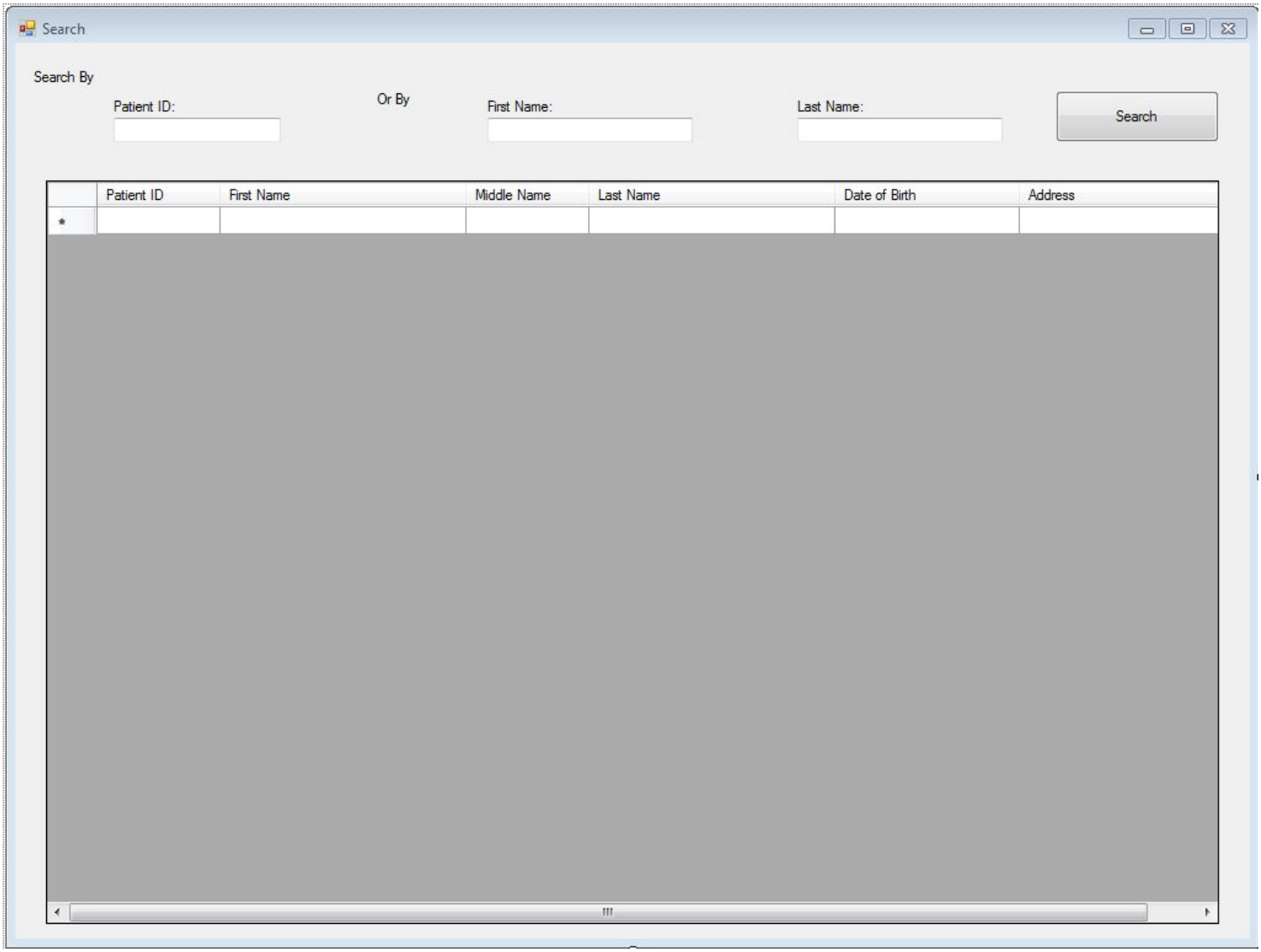
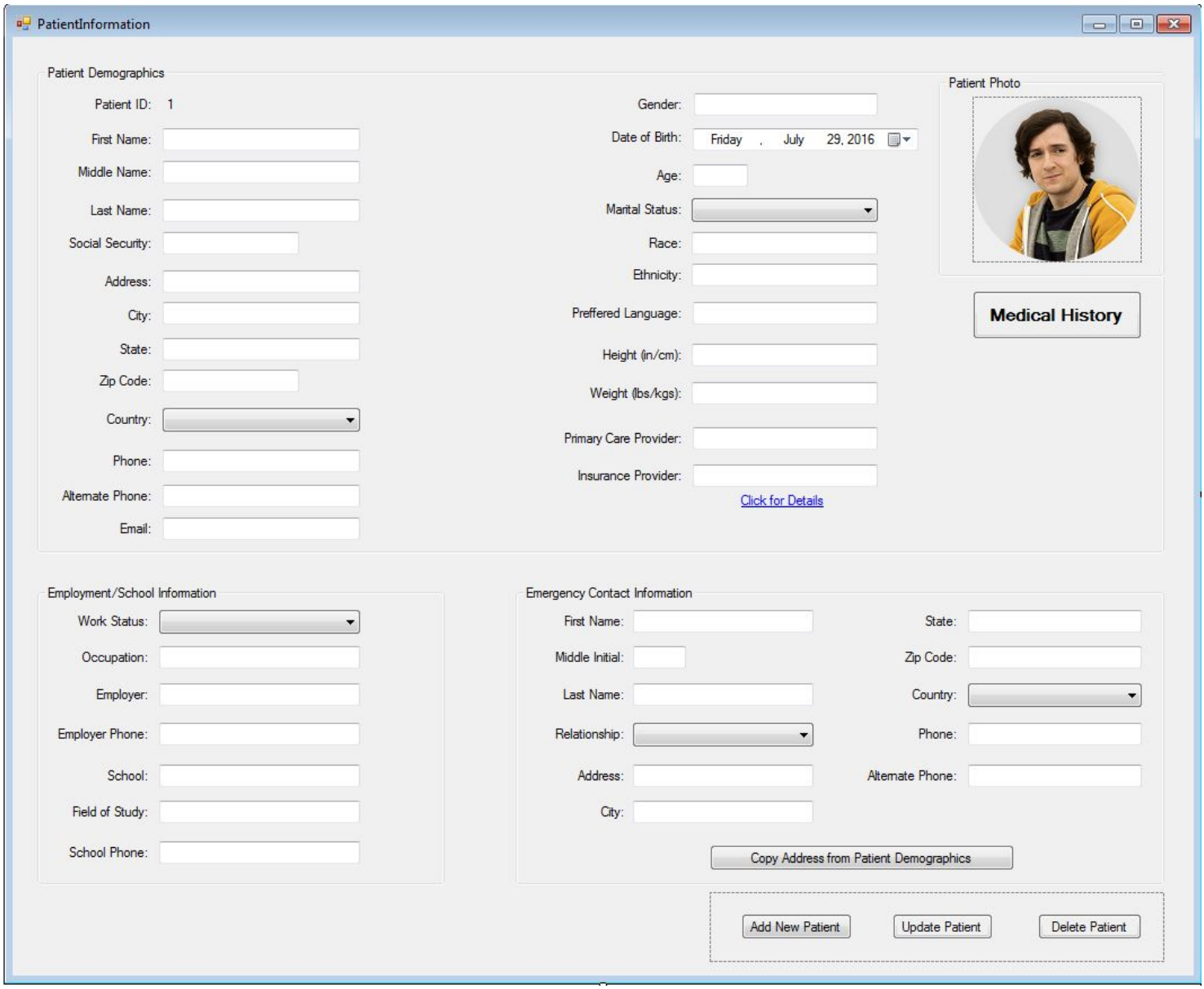
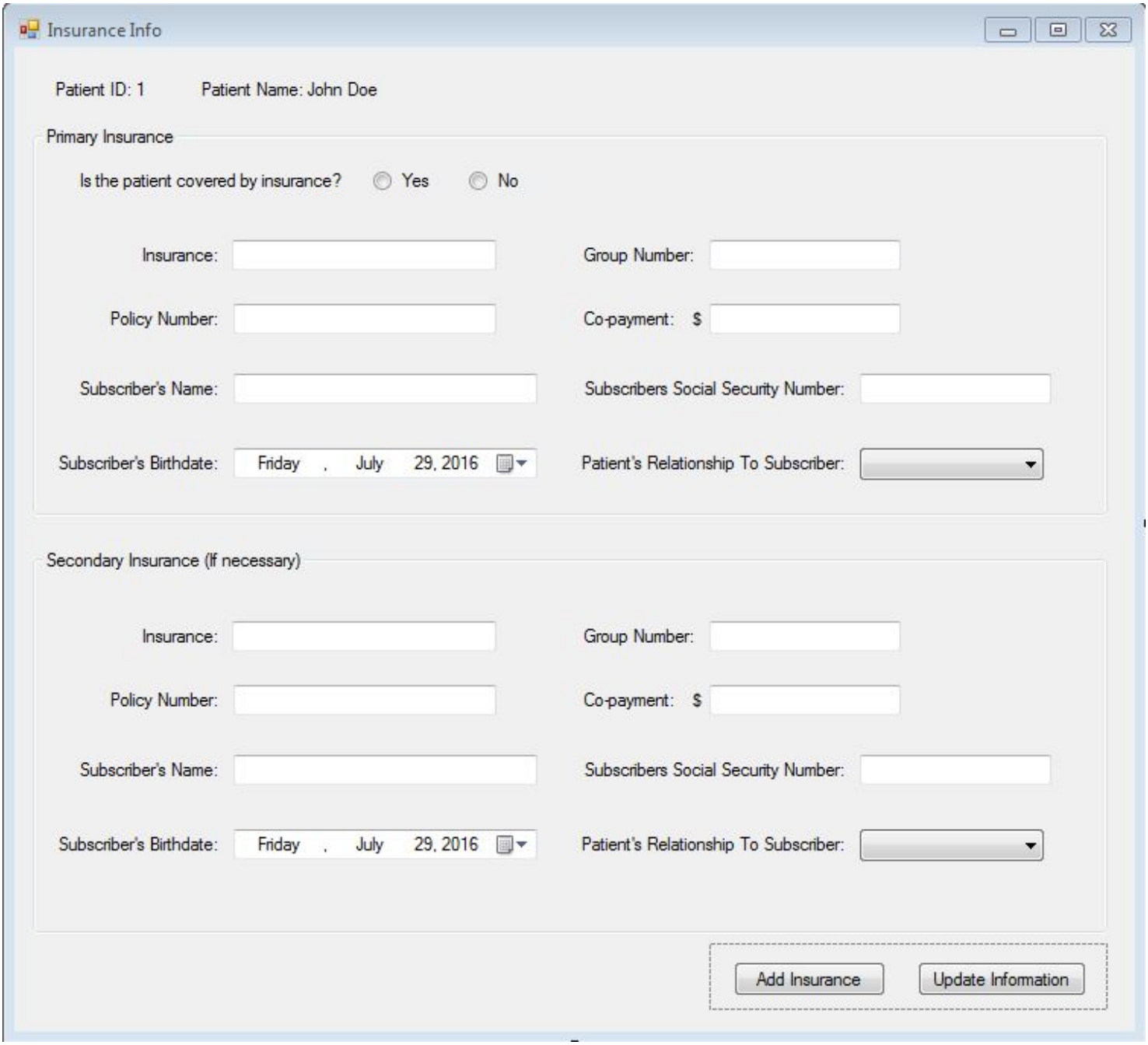
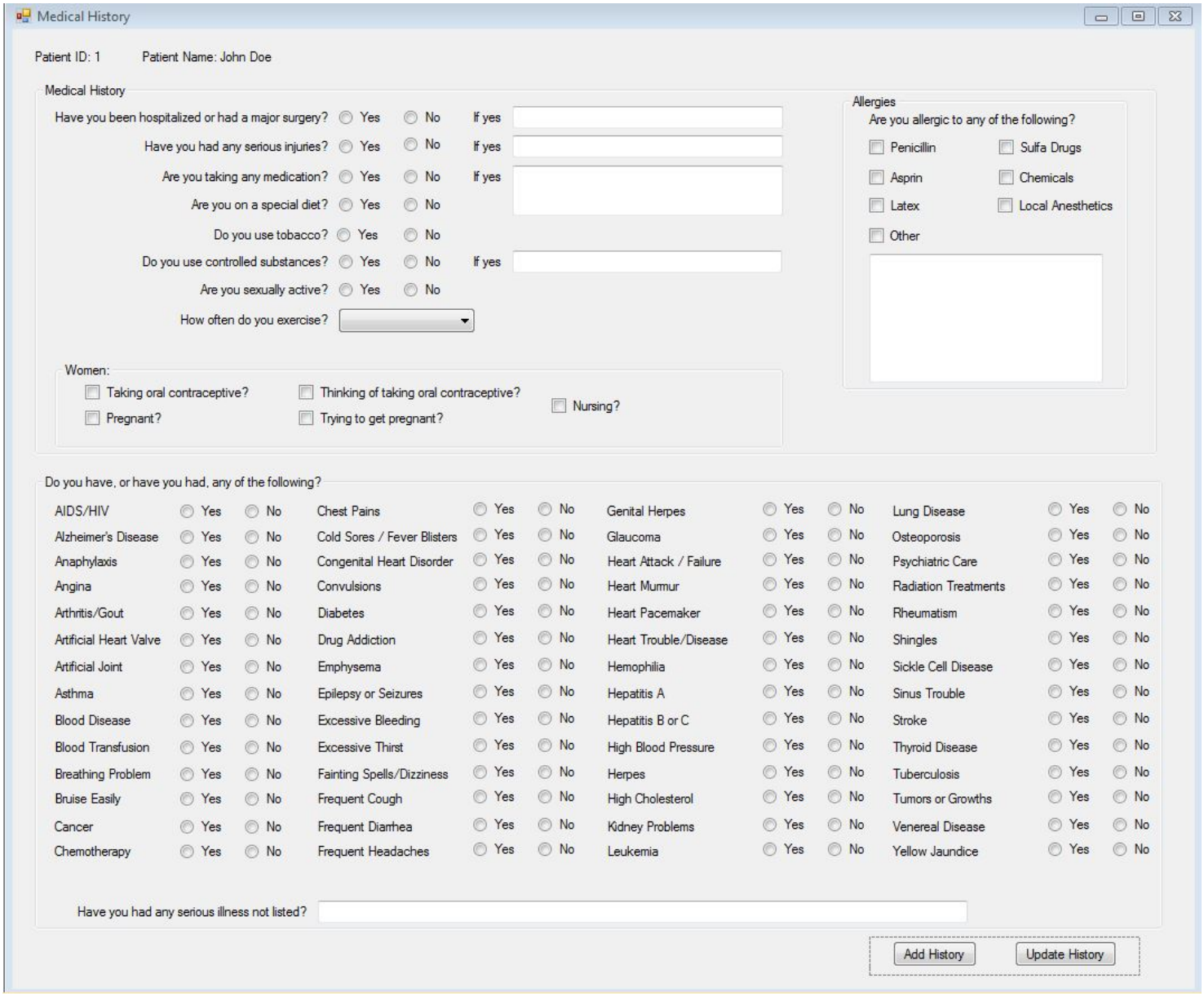

Login
Patient Records
Username:
Password:
-- Warning appears here when the wrong information is entered --
Login
Add New Patient
Search Patients


Search
Search By
Patient ID:
Or By
First Name:
Last Name:
Search
Patient ID
First Name
Middle Name
Last Name
Date of Birth
Address


PatientInformation
Patient Demographics
Patient ID: 1
First Name:
Middle Name:
Last Name:
Social Security:
Address:
City:
State:
Zip Code:
Country:
Phone:
Alternate Phone:
Email:
Gender:
Date of Birth: Friday , July 29, 2016
Age:
Marital Status:
Race:
Ethnicity:
Preffered Language:
Height (in/cm):
Weight (lbs/kgs):
Primary Care Provider:
Insurance Provider:
Click for Details
Patient Photo
Medical History
Employment/School Information
Work Status:
Occupation:
Employer:
Employer Phone:
School:
Field of Study:
School Phone:
Emergency Contact Information
First Name:
Middle Initial:
Last Name:
Relationship:
Address:
City:
State:
Zip Code:
Country:
Phone:
Alternate Phone:
Copy Address from Patient Demographics
Add New Patient
Update Patient
Delete Patient


Insurance Info
Patient ID: 1
Patient Name: John Doe
Primary Insurance
Is the patient covered by insurance?
Yes
No
Insurance:
Group Number:
Policy Number:
Co-payment: $
Subscriber's Name:
Subscribers Social Security Number:
Subscriber's Birthdate:
Friday , July 29, 2016
Patient's Relationship To Subscriber:
Secondary Insurance (If necessary)
Insurance:
Group Number:
Policy Number:
Co-payment: $
Subscriber's Name:
Subscribers Social Security Number:
Subscriber's Birthdate:
Friday , July 29, 2016
Patient's Relationship To Subscriber:
Add Insurance
Update Information


Medical History
Patient ID: 1
Patient Name: John Doe
Medical History
Have you been hospitalized or had a major surgery? Yes No If yes
Have you had any serious injuries? Yes No If yes
Are you taking any medication? Yes No If yes
Are you on a special diet? Yes No
Do you use tobacco? Yes No
Do you use controlled substances? Yes No If yes
Are you sexually active? Yes No
How often do you exercise?
Women:
Taking oral contraceptive?
Thinking of taking oral contraceptive?
Nursing?
Pregnant?
Trying to get pregnant?
Allergies
Are you allergic to any of the following?
Penicillin
Sulfa Drugs
Asprin
Chemicals
Latex
Local Anesthetics
Other
Do you have, or have you had, any of the following?
AIDS/HIV
Alzheimer's Disease
Anaphylaxis
Angina
Arthritis/Gout
Artificial Heart Valve
Artificial Joint
Asthma
Blood Disease
Blood Transfusion
Breathing Problem
Bruise Easily
Cancer
Chemotherapy
Chest Pains
Cold Sores / Fever Blisters
Congenital Heart Disorder
Convulsions
Diabetes
Drug Addiction
Emphysema
Epilepsy or Seizures
Excessive Bleeding
Excessive Thirst
Fainting Spells/Dizziness
Frequent Cough
Frequent Diarrhea
Frequent Headaches
Genital Herpes
Glaucoma
Heart Attack / Failure
Heart Murmur
Heart Pacemaker
Heart Trouble/Disease
Hemophilia
Hepatitis A
Hepatitis B or C
High Blood Pressure
Herpes
High Cholesterol
Kidney Problems
Leukemia
Lung Disease
Osteoporosis
Psychiatric Care
Radiation Treatments
Rheumatism
Shingles
Sickle Cell Disease
Sinus Trouble
Stroke
Thyroid Disease
Tuberculosis
Tumors or Growths
Venereal Disease
Yellow Jaundice
Yes
No
Have you had any serious illness not listed?
Add History
Update History